

ROOT CAUSE ANALYSIS OF INJURY/ILLNESS (Supplemental Form)

Hospital Name: _____ **Date of Injury:** _____

Injured Employee Name: _____ **Claim Number:** _____

1. What task was the injured employee performing prior to the accident / near miss? _____

2. Describe any tools, machinery or equipment that was being used at the time of the incident? _____

3. Was the employee working alone? Yes No With? _____

4. How much experience did the injured person have in performing this task? _____

STEP 1 – OBTAIN AND REVIEW PHYSICAL, PEOPLE, AND PAPER EVIDENCE PERTINENT TO THE INVESTIGATION.

- **Physical:** Sample Results (Air, Noise, Bulk, etc.)/ Photographs/Drawings/Equipment Manual/etc.
- **People:** Witness Statements & Interviews/ Employee Report of Incident
- **Paper:** Policies/Programs/Procedures/Training Records/Maintenance Records/Prior Incident Reports/etc.

STEP 2 – DIRECT, CONTRIBUTING, AND ROOT CAUSES

- Use this listing as an aid for identifying the factors that lead to the incident.
- Don't be limited by the categories listed--add items (Other) as needed. Check all that apply.

POLICIES/PROGRAMS ✓

Not Developed or Inadequate	
Developed – Not Communicated	
Developed – Not Understood	
Developed – Not Followed	
Lack of Disciplinary Policy	
Disciplinary Policy Not Enforced	
Other	

COMMUNICATION ✓

Insufficient Planning for Tasks	
Lack of Worker Communication	
Lack of Supervisor Instruction	
Work Team Breakdown	
Confusion After Communication	
Other	

HAZARD(S) ✓

Unidentified or Not Labeled	
Known But Not Corrected	
Known But Not Reported	
Created By External Factors	
Documented But Not Repaired	
Condition Changed Not Conveyed	
Equipment Repaired Deficiently	
PPE Not Adequate or Defective	
Other	

FACILITIES/EQUIPMENT ✓

Poor Facility Design	
Poor/Faulty Equipment Design	
Awkward Workstation Design	
Equipment Not Guarded	
Equipment Repair Deficient	
Lack of Preventive Maintenance	
Lack of Storage	
Other	

PRODUCTIVITY FACTORS ✓

Heavy Workload	
Tight Schedule	
Long/Unusual Working Hours	
Falsely Perceived Need to Hurry	
Staff Assistance Unavailable	
Staff Assistance Inadequate	
Changes in Process	
Other	

WORK BEHAVIOR ✓

Shortcuts Taken	
Required PPE Not Used	
PPD Not Used Properly	
Tool/Equipment Used Incorrectly	
History of Accidents/Incidents	
Disregarded/Refused to Follow Procedure(s)	
Staff Assistance Required - Not Requested	
Horseplay	
Other	

TRAINING ✓

Deficient Orientation Training	
Deficient Job-Specific Training	
Insufficient Training for New Process/Task	
Lack of Supervisor Follow-Up/Reinforcement	
Lack of Supervisor Training	
Hazards Overlooked in Training	
Other	

ENVIRONMENT ✓

Weather, Temperature	
Poor Housekeeping	
Poor Lighting	
Poor Visibility	
Air Quality	
Noise	
Other	

PATIENT HANDLING ✓

Transfer/Positioning Equipment Not Used	
Transfer/Positioning Equipment Not Used Properly	
Transfer/Positioning Equipment Not Available	
Equipment Not Adequate for Patient Weight and/or Size	
Area too Small to Use Transfer/Positioning Equipment	
Combative Patient	
Care Plan Not Adequate	
Care Plan Did Not Fit Patient Handling Policy	
Care Plan Not Updated When Patient Condition Changed	
Care Plan Not Followed	
Other	

BLOOD & OPIM EXPOSURE ✓

Needless System Not Available	
Needless System Available-Not Used	
Needle Device (needle cover, etc.) Not Used	
Sharps Container Not Located as Close as Feasible	
Sharps Container Overfilled	
Sharps Container Not Used (stuck in bed, etc.)	
Contaminated Needle Recapped	
Stuck w/Contaminated Needle/Sharp by Physician or Other Staff	
Contaminated Waste Not Labeled	
Blood/OPIM Not Properly Stored	
Activation of Safety Device	
Other	

STEP 3 – CAUSE(S)

- From the categories identified, circle the major cause(s) of the incident.

POLICIES/PROCEDURES

COMMUNICATION

HAZARD(S)

TRAINING

PRODUCTIVITY FACTORS

WORK BEHAVIOR

FACILITIES/EQUIPMENT

ENVIRONMENT

PATIENT HANDLING

BLOOD & OPIM EXPOSURE

